MDR Tracking Number: M5-04-1859-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division (Division) assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on February 24, 2004.

The IRO reviewed CPT Codes 99213, 97250, 97265, 97530, 97035, 99214, 97110, 95851, 99372 and HCPCS E-1399 for dates of service 02/28/03 through 05/08/03 that were denied based upon "V".

The Medical Review Division has reviewed the IRO decision and determined that **the requestor prevailed** on the issues of medical necessity. Therefore, upon receipt of this Order and in accordance with §133.308(q)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor $460.00** for the paid IRO fee. For the purposes of determining compliance with the order, the Commission will add 20 days to the date the order was deemed received as outlined on page one of this order.

The reviewer finds that the treatment including DME and reports rendered from 02/28/03 through 04/16/03 **was** found to be medically necessary. The review finds the treatment rendered from 04/18/03 through 05/08/03 **was not** found to be medically necessary. The respondent raised no other reasons for denying reimbursement for CPT Codes 99213, 97250, 97265, 97530, 97035, 99214, 97110, 95851, 99372 and HCPCS E-1399.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was not the only issue** to be resolved.

On June 29, 2004, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14-days of the requestor's receipt of the Notice.

- CPT Codes 99213, 97265, 97250, 97530 and 97035 for date of service 03/07/03. EOBs were not submitted by either party and will therefore be reviewed according to the 1996 Medical Fee Guideline. Per the 1996 Medical Fee Guideline, E&M Ground Rule (VI)(B), Medicine Ground Rules (I)(A)(9)(a)(iii), (c), and (11)(b) reimbursement in the amount of $191.00 ($48.00 + $43.00 + $43.00 + $35.00 + $22.00) is recommended.

- CPT Code 99080-73 for dates of service 03/10/03, 03/31/03, and 04/25/03 denied as "V". Per Rule 129.5 the TWCC-73 is a required report and the Medical

Review Division has jurisdiction in this matter. Per Rule 133.106(f)(1) reimbursement in the amount of $45.00 ($15.00 x 3) is recommended..

- CPT Code 99213, 97250, 97530 and 97265 for date of service 03/28/03 denied as "E". Review of the TWCC database and an information request from General Files' reveals a TWCC-21 has not been submitted by the carrier and will therefore be reviewed according to the 1996 Medical Fee Guideline. Per the 1996 Medical Fee Guideline, E&M Ground Rule (VI)(B), Medicine Ground Rules (I)(A)(9)(c), and (11)(b) reimbursement in the amount of $169.00 ($48.00 + $43.00 + $43.00 + $35.00) is recommended.

- CPT Code 97110 for date of service 03/28/03 denied as "E". Review of the TWCC database and an information request from General Files' reveals a TWCC-21 has not been submitted by the carrier and will therefore be reviewed according to the TWCC Rules. Recent review of disputes involving CPT Code 97110 by the Medical Dispute Resolution section indicate overall deficiencies in the adequacy of the documentation of this Code both with respect to the medical necessity of one-on-one therapy and documentation reflecting that these individual services were provided as billed. Moreover, the disputes indicate confusion regarding what constitutes "one-on-one." Therefore, consistent with the general obligation set forth in Section 413.016 of the Labor Code, the Medical Review Division has reviewed the matters in light all of the Commission requirements for proper documentation. The MRD declines to order payment because the SOAP notes do not clearly delineate exclusive one-on-one treatment nor did the requestor identify the severity of the injury to warrant exclusive one-to-one therapy. Additional reimbursement not recommended.

- CPT Code 99213, 97250, 97530 and 97265 for date of service 05/01/03. EOBs were not submitted by either party and will therefore be reviewed according to the 1996 Medical Fee Guideline. Per the 1996 Medical Fee Guideline, E&M Ground Rule (VI)(B), Medicine Ground Rules (I)(A)(9)(c), and (11)(b) reimbursement in the amount of $169.00 ($48.00 + $43.00 + $43.00 + $35.00) is recommended.

- CPT Code 97110 for date of service 05/01/03. EOBs were not submitted by either party and will therefore be reviewed according to TWCC Rules. Recent review of disputes involving CPT Code 97110 by the Medical Dispute Resolution section indicate overall deficiencies in the adequacy of the documentation of this Code both with respect to the medical necessity of one-on-one therapy and documentation reflecting that these individual services were provided as billed. Moreover, the disputes indicate confusion regarding what constitutes "one-on-one." Therefore, consistent with the general obligation set forth in Section 413.016 of the Labor Code, the Medical Review Division has reviewed the matters in light all of the Commission requirements for proper documentation. The MRD declines to order payment because the SOAP notes do not clearly delineate exclusive one-on-one treatment nor did the requestor identify the

severity of the injury to warrant exclusive one-to-one therapy. Additional reimbursement not recommended.

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20-days of receipt of this Order. This Order is applicable to dates of service 02/28/03 through 04/16/03 and 04/25/03 and 05/01/03 in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Decision and Order is hereby issued this 29th day of October 2004

Marguerite Foster
Medical Dispute Resolution Officer
Medical Review Division

MF/mf
Enclosure: IRO decision

May 26, 2004

David Martinez
TWCC Medical Dispute Resolution
4000 IH 35 South, MS 48
Austin, TX 78704

Patient:
TWCC #:
MDR Tracking #: M5-04-1859-01
IRO #: 5251

Ziroc has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this case to Ziroc for independent review in accordance with TWCC Rule 133.308 which allows for medical dispute resolution by an IRO.

Ziroc has performed an independent review of the care rendered to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

The independent review was performed by a matched peer with the treating doctor. This case was reviewed by a licensed Doctor of Chiropractic. The reviewer is on the TWCC Approved Doctor List (ADL). The Ziroc health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors or providers who reviewed the case for a determination prior to the referral to Ziroc for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

CLINICAL HISTORY

___ injured her left knee when she twisted the knee while trying to avoid a falling skid on her job. She was initially treated by Dr. Hudgins with passive and active care for the injury. She was treated and then released back to full duty on January 29, 2003 after being fitted for a knee brace. When the knee did not get any better, the patient was examined with MRI of the knee and a medial meniscus tear was diagnosed. She underwent surgical intervention on May 9, 2003 by Robert Ranelle, DO. A designated doctor, Michael Davenport, DC, found the patient to be at MMI as of February 22, 2003 with 1% impairment. He later changed his opinion and found the patient was not at MMI based on the surgical intervention. A peer review was performed by David Niekamp, DC on March 9th, 2004 and found that ongoing care on this case was unreasonable based on the 1% MMI. Dr. Niekamp indicates that he does not have a complete set of records from which to judge this case. A file record from the surgeon of record indicates that surgery was recommended on April 16, 2003. Records indicate that the treating doctor continued treating pre-surgically to attempt to prevent de-conditioning. Records on this case were received from both the carrier and the requestor and include office notes, MRI, the designated doctor's reports and the reports of consulting doctors to include the surgeon and peer reviewer.

DISPUTED SERVICES

The carrier has denied the medical necessity of Level III and IV office visits, myofascial release, therapeutic activities, joint mobilization, ultrasound, miscellaneous DME, therapeutic exercises, range of motion, special reports and telephone conferences from February 28th 2003 through May 8th 2003.

DECISION

The reviewer finds that treatment as rendered was reasonable from February 28th through April 16th 2003. Treatment after that date was not medically necessary. The reviewer does find that DME and reports are all medically necessity. The reviewer does not find adequate documentation of telephone conversations and finds that it is medically unnecessary in this particular case.

BASIS FOR THE DECISION

It is clearly the responsibility of the treating doctor to attempt to rehabilitate a patient when treating an injury. If that injury is, as in this case, a meniscus tear the care attempted should reasonably be expected to get the patient back into a working environment. The treating doctor clearly utilized mostly good judgment in this case while using conservative care on a reasonable basis. However, after it was determined that conservative care had indeed failed and that the patient was to undergo surgery, it is once again reasonable that the treating doctor should have ended the physical medicine at that point, only to resume after the surgical intervention. As a

result, the treatment up to and including April 16th was reasonable. After that point, for the purpose of this dispute, the care cannot be justified by the records received from the treating provider. The records indicate that TWCC required reports were filed and were done so as required by the rules. These should be reimbursed. The telephone conferences are not adequately documented in the records to indicate the necessity of such billing.

Ziroc has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. Ziroc has made no determinations regarding benefits available under the injured employee's policy

As an officer of ZRC Services, Inc, dba Ziroc, I certify that there is no known conflict between the reviewer, Ziroc and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

Ziroc is forwarding this finding by US Postal Service to the TWCC.

Sincerely,

Nan Cunningham
President/CEO

CC: Ziroc Medical Director